2026 GLOBAL CONFERENCE
LEADING IN A NEW ERA

THE ECONOMIC CASE FOR HEALTH EQUITY

Uché Blackstock 00:11

Thanks so much for joining us. Very excited to be here for the panel, "The Business Case for Health Equity." So when I think of health equity, I don't first think about policy or even investment. I think about my mother, the late Dr. Dale Blackstock, who practiced in Central Brooklyn in New York City under very different circumstances than today in the '80s and '90s. And she and her colleagues were practicing really holistic care, thinking about the whole person. And so that's the influence that I had, and that's why I went into medicine. So in my own work, I often see how we talk about equity at a high level, but don't always connect it to how decisions are actually made inside institutions, how resources are allocated, or how success is measured. So as we have this conversation, I'm going to push us to move beyond intention, in thinking that health equity is not separate from economic performance, and really focus on what this looks like in practice and what leaders in this room can do differently. So I'm very excited to introduce our panelists, Dr. Wayne Frederick, Dr. Allison Goldberg, A.C. Locklear, and Kent Thoelke. And you can read their impressive bios online, and I'm sure they'll share a little bit about it in their questions. But before we dive in, I wanted to level set a little because we have a global audience here. Level set in a slightly different way. If we're going to make the economic case for health equity, we have to be clear about what health equity actually means. So I'd like to go down the row. From your respective vantage point, how are you defining health equity now, and what makes that definition actionable?

Wayne A. I. Frederick 02:04

Yeah. So, thanks for having me. One of the things I've been thinking about a lot with respect to health equity is discussing lifespan versus healthspan. And I think the more that we can decrease the time between healthspan and lifespan, extending both, I think you create health equity for all. And if that is equal amongst all groups, regardless of demographics, geography, income level, then I think that we've created an equitable health care opportunity.

Uché Blackstock 02:34

Thank you. Dr. Goldberg?

Allison Goldberg 02:36

So I have the privilege to work for a big pharmaceutical company that is very committed to putting science into action. And from a philanthropic perspective, as well as from a broader company perspective, we're committed to improving access to health for all people everywhere. So when it comes to what we do philanthropically, what I would say is that we're very serious and committed to thinking about ways that we can reach populations who have been underserved around the world. So we're very committed to that, and that's how we're thinking about health equity.

Uché Blackstock 03:09

Okay.

A.C. Locklear 03:12

Yeah, so it's a little bit different for Native communities because we have a sovereign relationship with the United States government. We exchanged millions of acres of land in treaties for the exchange of a lot of things, but one of them being health care. And right now, the US government, in fulfilling that, probably fulfills it about 50 cents to every dollar. So for us, it's really about upholding that sovereignty, upholding that status, and really allowing tribes to make those decisions for themselves as sovereign entities, giving them the power and letting them really meet the needs of their communities. And that's really how we define health equity, what tribes are able to do for their communities, and how are they able to incorporate culture, traditional healing, things that are really central and pivotal to health and well-being for our communities, and that's how we see it.

Uché Blackstock 04:02

Thank you. Kent?

Kent Thoelke 04:04

I think it's a big umbrella, so I'll narrow in onto our part of the world at Paradigm. So, we think about health equity in the framework of clinical trials and clinical trial access and access to novel medications. And the reality is five-ish percent, maybe 7 percent of patients in the US participate in clinical trials today. Non-white patients are a fraction of that, maybe 1 percent. And the reality is 80 percent or 85 percent of all patients get their care delivered in a community or rural setting today, and 90 percent of all trials take place in urban centers and academic medical centers. So the disconnect between that is a massive disproportion around health equity. And for most diseases today, access to a clinical trial may be the difference between actually living and dying, or actually living a healthy life and a long-term life without comorbidities. So we think about it in that respect.

Uché Blackstock 04:58

Cool, thank you. And it sounds like from your different vantage points that there's sort of different perspectives. You're thinking about healthspan, you're thinking about the impact globally of your philanthropic work. A.C., thinking about tribal sovereignty, right? And then Kent, about access. And so I want to get a little bit deeper, so building on that. If health equity is truly also economic infrastructure, why isn't it being treated that way in how capital is allocated today or always?

Wayne A. I. Frederick 05:31

I think it's a reflection of shortsightedness in our economic system in general. I'll give you an example. In Washington, DC, the nation's capital, a Black man who lives in Ward 7 and 8 has a life expectancy of about 22 years less than a white woman living in Ward 3. So when you think of the economic impact of living 22 years less than someone, even if you made the same amount they made, you can do the math. You can do the compound interest. You live 22 years less than somebody else, you're not going to create generational wealth. Also the productivity. The second thing I will say is, during the pandemic, we learned a very grave lesson, especially in DC. Most of us have forgotten this, but at one point, you had to get a prescription to get a COVID test. We take those things for granted now, but think of the barrier that created for people who were going out every day and serving our communities. And so Howard set up the first testing in Ward 7 and 8.

Uché Blackstock 06:27

The Howard University?

Wayne A. I. Frederick 06:29

Yes.

Uché Blackstock 06:29

Okay.

Wayne A. I. Frederick 06:29

Howard University set up the first testing in Ward 7 and 8, where you could just walk in and get a test. And that was really the first sign to us that there was a problem with people who were traveling across the city to go serve people in restaurants and elsewhere. The COVID incidence was high, and that's another example as well when you look at the productivity. Our overall productivity as an economy is really based on all of us being as productive as possible, and when we take that opportunity away because we don't have a healthy population across the board, I think it also impacts the economy. So it makes a lot of sense to really ensure that the least of us are really getting the best of our health care.

Uché Blackstock 07:12

Thank you.

Allison Goldberg 07:15

For us, I would say that we look at corporate philanthropy specifically as a unique tool, and it's a unique tool for us to take smarter risks, to catalyze towards solutions that can have great local impact. We obviously work in the health space. That's what we're focused on doing, is closing those critical gaps in care, which vary based on local realities and local contexts. But we know that there's a strong connection between health and wealth, right? So us, when we're thinking about how we're going to make a difference, we're thinking about the ways that we can address some of those critical barriers to health. What are some of those wraparound needs that we need to address that hopefully we can help to resolve, in partnership with others and in partnership with local communities, and doing that in a way that has the potential to be sustainable. And I don't know how much we're going to talk about sustainability.

Uché Blackstock 08:12

No, go ahead.

Allison Goldberg 08:12

But for us, although the investments we make are catalytic, the real opportunity is to make those catalytic investments that have that potential for sticking, for staying around after we make those initial investments.

Uché Blackstock 08:27

Thank you.

A.C. Locklear 08:28

Yeah. It's very interesting. Self-governance and the ability for tribes to run their own health system is very fairly new. Most of the times, most people have never met an American Indian, Alaska Native person. They have no idea how health is impacted in tribal communities. And most of the time we are underrepresented or not represented at all in many studies, trials. Pretty much any outcome related to health, there's an asterisk because we're very undercounted or not represented at all. So just understanding the system of health and how it impacts tribal communities is foreign for pretty much most of the world. And it's just the reality, yet the biggest innovations are happening in Indian Country. If you want to know an answer to a problem in rural health care, go to Alaska. They've probably figured it out, and it's something that we're trying to expose folks to. Because of the relationship with health, for many years, most of that health care was provided by the federal government, and still is in a lot of cases. But now, about 65 percent of the Indian Health Service budget is controlled by tribes and tribal health facilities. And it's increasing at an enormous rate. So you see things like community health aides, behavioral health aides, dental health aides, all these different mid-level providers and innovations across the board starting in Indian Country. But it's just not something that there have been sustainable partnerships or those relationships to really elevate a lot of that. And that's something that we're really working to elevate as we move forward in Indian Country.

Kent Thoelke 10:00

I think we live in these discrete boxes and silos, and so we think about the economic impact, and you start talking about clinical trials, and people instantly think, well, those are pharmaceutical companies, right? Pharmaceutical companies make billions of dollars. And so it gets distracted right away. The reality is that clinical trials and pharmaceutical companies in the rural and community health care setting offset a tremendous amount of cost to those systems in providing access to medications that, quite honestly, many of those patients couldn't even afford the copay for if they're on Medicare or Medicaid. Roughly 40 percent or 50 percent of all the patients that are served in our community and rural systems today are on Medicare and Medicaid. If you step back for a minute and you think about an elderly patient in North Dakota with lung cancer, the comorbidities of not getting them appropriate care, cost to the CMS system, Medicare, Medicaid, long-term, for those comorbidities, we're talking about hundreds of billions of dollars. And when we're in a cycle where the government is cutting back on things like CMS, and they're cutting back on NIH funding, the only people that can take that up are the pharma companies. And so we've got

to get out of this idea that there's all these discrete boxes and think about the economic impact on a kind of ecosystem basis.

Uché Blackstock 11:15

Okay. That segues very well into my next question about investment to impact. And I think Kent, you talked a little bit about this, and A.C. too. But what actually determines whether investment translates into impact on the ground, and where have you seen models that are working? I'd like Dr. Frederick to start first because I know he probably has a lot to share with us.

Wayne A. I. Frederick 11:37

I'm in the hot seat here. I would say there are two things. One is—and I'll unfortunately personalize this a little bit. I suffer from two diseases. I have sickle cell anemia, for which I'm homozygous, and I also have type 1 diabetes. And so while I'm sitting here, I have a sensor on and an insulin pump, and I have a closed-loop pancreas. So I don't have to regulate my blood sugar, et cetera. You think of something like that, and you think of the amputation rates in underserved communities or low-income communities where patients don't have access to insulin, they don't have access to finger stick testing, they don't have access to physicians to monitor them closely. You think of the amputation rate, you think of the lack of productivity and what that does to the GDP. It's a significant impact. So I think how we invest in technology, for instance, and do that. And then the other is sickle cell. I'll turn 55 in June, and in my lifetime, I've seen a cure for a disease that I was born with, and born in a country where I thought I would live to 88. And today, I've met people who've now hiked Kilimanjaro, very productive parts of the community, not living in pain. And so again, when you think of the economic investment of something like gene therapy—right now gene therapy costs $3 million. But just imagine what gene therapy could do to a place as that technology improves. It could do it to a place like Congo that has the highest incidence of the sickle cell gene, and where the infant mortality rate is through the roof. But think of us maybe 10, 15 years down the road being able to get that therapy to a place where you could impact an entire country like Congo, and you can have young people really thrive in that country. So I think that investment of technology and trying to, for lack of a better word, democratize it so that it's accessible to a wider range of people, is probably a better investment than treating people after they have an amputation, et cetera. And we don't often think of that, right? We think to give somebody an insulin pump is an expensive thing to do, et cetera, but you avoid amputations, end-stage renal disease, blindness in particular communities. You certainly increase the productivity and ultimately GDP, to be quite honest.

Uché Blackstock 13:59

Thank you. Thank you for sharing about your personal story, and then also in terms of patient outcomes. But I'm also curious about Howard's impact on community and workforce, and what that investment also looks like.

Wayne A. I. Frederick 14:13

Sure. The pipeline is incredible. At the turn of the previous century, Abraham Flexner was charged to go throughout North America, US and Canada, to every single medical school. It's probably one of the most incredible research—

Uché Blackstock 14:28

This is important history lesson for everybody.

Wayne A. I. Frederick 14:31

Yeah. One of the most incredible research operations ever conducted. And he looked at every medical school and determined which medical schools should survive because they had really good prerequisite training, good research, et cetera. I like to say this, that when he did that, he said that the only medical school in DC that should stay standing was Howard, but I'll leave that for another day. But there were eight Black medical schools. We went down to two. We now have four. 3 percent of medical students at that time were Black. Today, 3 percent of medical students are Black. So we have not done a good job of filling the pipeline. Howard has produced more Black physicians than any other institution in the country. If Howard were to stop admitting medical students today, it would take 25 years for the school that is behind it in terms of producing Black physicians to catch up to the number of Black physicians we produce. So clearly, there's an issue. Now, that doesn't mean that every Black patient needs to see a Black physician. That's not my point. But what we do at Howard, because we have a mixed population of students, is we create a cultural competency that is very important to understand that. And the last point I'll make about this is that that cultural competency doesn't know race, color, or creed. When I went back to Howard as a surgical oncologist after training at MD Anderson, I took care of a 40-year-old woman with breast cancer. I operated on her. She had to go to chemo on a Friday. I'll never forget. I got a call that she didn't show up. I called her Saturday morning, and for 90 seconds, I went on about why she needed chemo to go along with the surgery she had. She listened calmly, and then she quietly said to me, "Dr. Frederick, I apologize, but it's the end of the month. I'm a wage worker. I had to go to work to take care of my five kids." Now, I don't care what kind of medicine you create, that is a conundrum that our society is often faced with. And you don't think a patient with cancer has any other priority other than getting her chemo, and that's just not true. People are trying to eat, they're trying to take care of their families, and that's an incredibly painful construct. And even me, who went to Howard, saw patients in that circumstance still. And so just imagine how the further away you get from that circumstance, the more inept you are at really relating to people and making sure you create treatment programs that accommodate them, versus what we do now is we tell people to fit into what we do. So I think that cultural competency that we try to give our students at Howard is also a critical part of this discussion.

Uché Blackstock 17:17

Thank you for sharing that. Investing in a workforce that can competently care for a patient population. I'm just going to hop over to A.C. in terms of investment and impact on the ground. How do you see that in the work that you've done? We shared before the panel that you've been traveling so much, talking to so many different communities, right? Can you share some models that you feel like are working?

A.C. Locklear 17:40

Yeah, absolutely. I think there was actually a report that was released either today or yesterday, and it was in conjunction with the CDC on the Special Diabetes Program for Indians, and it's been touted as one, if not the second most successful public health intervention in the history of the United States, next to childhood vaccinations. And because it basically invests in tribal communities to solve the issue. It doesn't matter if they have food kitchens, food tutorials, building a playground, incorporating traditional dances, clearing the pathways so the elders can walk to and from sacred sites. It has reduced kidney disease by about 30 percent overall in the last 10 years just in tribal communities, and that's just one of the ways.

Another example is the Nuka system of care up in Alaska, an integrated care model where essentially they create a team of providers, a case manager, nurses, behavioral health aides, everyone, who's basically assigned to a family, to a person. When they go to see their primary care physician, there is every intervention that needs to be had within that system, right there, the day they go to the clinic. And traditional healers are also a part of that in conjunction with Western medicine. But the key is that they are not investing in a project. They are not investing in, "Hey, here's this idea that we have. Here's this Western solution that we want to see if it works for your community." They invest in the infrastructure. They invest, and that's where the key and the successes lie, is the ability for, whether it's the federal government, philanthropy, whomever it is, to invest in the infrastructure to say, "Here is the money for you to do what you need to do. We're not going to give you the confines of you have to do it this way, you have to do exactly as we say, you have this reporting requirement. You're a sovereign nation. You've been doing this for thousands of thousands of years. Here's money to help you solve this problem in your community." And we see it time and time again, when that freedom and that sovereignty is respected through that way, it works.

Uché Blackstock 19:48

Thank you.

Uché Blackstock 19:50

Kent or Dr. Goldberg, anything to add?

Allison Goldberg 19:52

Yes. So to build on what A.C. has just shared, during this period where we're facing a lot of compounding pressures and we're experiencing it, a lot of this isn't new, but it is compounded. We're seeing pressures on program structures, health systems that are being strained, and as a result of that, we've also pivoted in ways that we've started to catalyze our social investments. And so one of the things that we've done is we started a grant program called Solutions for Healthy Communities. And what's interesting about that program is that it's a two-year grant program. What we do is we support community-led solutions to address gaps in care. And so it's not that prescriptive process like you outlined. It's about offering the opportunity for stakeholders in local communities and local leaders with the expertise to say, "We know what gaps we need to close. This is the way to do it, and this is how we'd like to have that supported." And so we're really proud of that program. We've seen great traction, I think for many of the reasons you described, and really strong impact. And that program, we just announced the second cohort of that program, but we now are operating in over 40 different countries, and we have over 60 grantees.

Kent Thoelke 21:14

I do think that to the side where Merck comes in, but also private capital has to step in here as well. This can't always be government funding. And so we were particularly lucky. Ken Frazier, who is the CEO of Merck, is on my board. Ken came very early on and said to the entire board of the investors, "This is not a thing we will solve overnight. This is not something we will solve with $5 or $10 million. This is a long-term investment to make sure that"—and you need that type of leader and voice to say, "We all have to be committed that if this doesn't make money for the private markets in a year or two, we're still committed that this won't go away." And that investment by visionaries like Ken, Bob Nelson over at Arch. But interestingly, this is not just a US problem. We talk about global side, right? Three of our largest investors

are ex-US. One is a sovereign wealth fund, Mubadala Capital. You would ask, "Why would they be involved in US health care?" US health care is a critical component to the global ecosystem for how we show up and serve globally. And so those types of investments and long-term vision are critical. But folks like Ken keep the ship going in the right direction.

Uché Blackstock 22:30

Thank you so much for sharing that. I wanted to go back to A.C. When we think about impact and investment, in terms of decision-making power, so I want to ask you, who actually holds the decision-making power over where resources go today, and then who should?

A.C. Locklear 22:48

That's a great question. It depends on where we are and where we are in the community. I think—simple enough that in terms of tribal communities, in terms of even local communities, it should be held within those communities. Tribal nations should have the ability to make those decisions themselves, in partnership with philanthropy, in partnership with the federal government. We don't live in an alternate reality where we know and can think we can do it without the resources. But we've seen over the last 50 years in self-governance, when tribal nations are empowered and given the ability to do things, build economic development, run their own health systems, they take it and they run. And they create immaculate and amazing health systems that rival pretty much any in the country. Right now, they still have a lot of regulatory issues that they have to face. They still have a lot of the same barriers that many others have to face. But you see a lot more of those partnerships and sitting across the table and having those conversations than ever before.

Uché Blackstock 23:55

Okay. Thank you. And so Dr. Frederick, leading an institution, what's your perspective on power sharing?

Wayne A. I. Frederick 24:02

It's interesting. I ran the American Cancer Society for 10 months, and I probably got more insight around that because at the same time that the US government was making a decision to decrease investment in research, people were expecting the American Cancer Society to fill the void. And coming in, I said, "Okay, great. We'd be happy to step up," et cetera. And then reality hit me. We invest probably $300, $400 million a year, the American Cancer Society, in cancer research. Overall, at any given time, we probably have about $700 to $800 million invested. The budget for the NCI is $6 billion.

Uché Blackstock 24:45

Yeah.

Wayne A. I. Frederick 24:46

So when you think of the gap that you're talking about filling, it's unrealistic, and I don't think we always appreciate just how much the government puts in. Now, we can have an argument all day about what we should put it into and how much, but we cannot lose sight of the fact that one of the cornerstones of American exceptionalism has been our research universities and the research activity that we have had in

this country. And any time we start decreasing that without rationalizing what that decrease looks like, we're going to get ourselves in trouble. And I think that was an eye-opening experience for me. So when we think of control and we think of the discussion, I think it is an important discussion to have as to what we're investing in and how, but I think we have to be very careful that we don't just simply de-invest, because we will get ourselves in a very, very bad situation.

Uché Blackstock 25:41

Thank you. Dr. Goldberg or Kent, anything to add to that?

Allison Goldberg 25:45

Yeah, no, I agree fully. I think that what it's going to take is, we've said this word, but it's been infused in some of our comments, which is the role of partnership in this. We're operating in a different kind of environment. I think that the role of partnership in this, so that we can lean on each other even more to help facilitate change and transformation in a way, and also just to weather some of the challenges and adapt and thrive in this environment, is going to be increasingly important.

Uché Blackstock 26:17

Yeah.

Kent Thoelke 26:17

I agree with all that.

Uché Blackstock 26:19

Okay. Well, actually, my next question is for you. It's around innovation. Because we're seeing rapid innovation in AI, how clinical trials function, and I wanted to ask you, what are guardrails that are needed to ensure those advances, and we spoke about this a little bit, expand access rather than reinforce inequities? And so you're doing a lot of really wonderful work with clinical trials. And we talked about making sure they're representative of communities. If you could talk a little bit more about that.

Kent Thoelke 26:48

Yeah. So, the clinical trial industry is 40 or 50 years old. The modern ecosystem for developing drugs is about the same. The reality is, for 99 percent of that time, we have developed drugs for white, middle-class men, and that's what we've done. And it has biased and selected out all of the people, a lot of the people, that get access to those drugs. That's bad for lots of reasons. It's bad for science. It's bad for health care. It's bad for economics. Start with gender alone. A lot of the drugs we approved didn't take into account different metabolism for gender. All of these things, diversity, relative genetics, there's all these reasons it's bad. The pharmaceutical industry, in the advancement of science, has created protocols for clinical trials that have become more and more complex and more restrictive. And if you just take a base trial and you say, "We're going to test a new drug and require that a patient needs to come into the clinic three times a week and get their blood draws, and they need to come in twice a month," and that center is several hours' drive for them. If you are in a marginalized community, if you're in a rural setting, if you are a parent with children, if you are impacted by the fact that you have an hourly job and no paid time off, by

the very nature of how we designed the trials to approve these drugs, you have ruled out all of those patients. They can't take off time. They can't afford to get daycare for that. They can't imagine doing all of that just to get access to a trial. And so by the very nature of how we design these trials, we have created that bias. How AI can help that, so our company goes into rural and community health care systems. We embed ourselves in the electronic medical record. We use AI to understand how patients are treated in the community and rural setting. The patient that gets their access and care in the community rural setting is completely different than a patient that shows up at an academic medical center. And so we take all of that data, and then we go to a Merck or a J&J or a BMS, and we say, "This is how patients are treated in the community and rural setting. As you design your protocols, they should mirror how those patients get their care. Because if we artificially create barriers that say these patients can never access the trials, we won't solve for this problem." That sounds simple, but the reality is, most health care systems have no idea how they actually treat their patients in aggregate. And so AI allows us to do that very quickly, take all that information, inform our biopharma partners that say, "This is how we solve for this piece." We remove the barrier by creating protocols that are still scientifically rigorous but aren't biasing what patients can participate.

Uché Blackstock 29:34

Very fascinating. And anyone on the panel have a question for Kent about this? No? So I think we talked in the back, but I was going to ask you, so how are we ensuring that AI doesn't perpetuate those biases? So, specifically in terms of representation, right? Can you tell us a little bit about—in the work that your organization is doing?

Kent Thoelke 29:57

It's really interesting. I think I was reading an article a little while ago around software coders and developers and the fact that in health care, female coders develop their code differently than male coders because their lived experience for how they deliver and get their health care is completely different. So I think the first thing is, when you create a company, you think about the people that are creating the tools. And especially for artificial intelligence and in health care, you need to have a diverse population creating the tools for the tools that are being delivered. So, I think that is how we think about that. I think that we spend a lot of time in our ecosystems understanding how health care is delivered in that specific center. So how health care is delivered in rural North Dakota is not the same how health care is delivered in rural Eastern Oregon. Those are different populations. And so we try to understand how those workflows are solving these problems. We use AI for some of that to help the individual physicians and health care systems understand their own data. But that's how we try to minimize the bias to ensure the people creating the technology aren't creating the bias themselves.

Uché Blackstock 31:05

Thank you for sharing that. And while we're talking about just innovation and issues of trust and accountability are coming up, I have a question. I'll start with Dr. Frederick. If trust directly impacts outcome, what would it look like to actually operationalize and measure it from inside institutions? And we can go down the row with that.

Wayne A. I. Frederick 31:23

Sure. One of the things that concerns me right now in medical education is that if you look across the US medical education system, not a lot of schools have AI incorporated into the curriculum. And I think that's very concerning. We're practicing medicine now at a—in a dynamic that is incorporating AI, but the average medical student that's graduating from medical school has no clue other than how they interact with AI outside of what they learn in the classroom. And I think that that's a huge deficit in our system. Our curriculum is not really, I would say, incorporating AI in those issues. And trust is extremely important, but trust has to come in a two-way circumstance, and how we interact and bring that in is very important. We saw that during COVID. I remember my team coming to me and saying, "One of the drug companies really late on wanted us to participate in a clinical trial so we could get more diverse patients," and I said to them, "There's no way." The treatments were out, there were other vaccines at that time that were out. And I said to them, "There's no way we're going to be able to recruit patients." But we signed up for it and sure enough, within 30 days, we met our quota. And a lot of it had to do with trust. People were willing to come to us and say, "You guys are Howard, we trust that this is what you're going to do." And that trust is not just about that you look like somebody. We have a picture that I still keep on my desk of a woman who was 105. She lived through the first pandemic and she came to us to get her vaccine, which she got from an 18-year-old Black nursing student. And that picture still sits on my desk, because in 100 years—her joy, she said—she said that she never thought that she would be in a circumstance like what she lived through, which she was told about more than experienced, but to come back almost a hundred years later and have this happen, but have an 18-year-old Black nursing student give her that vaccine—and so that trust is not—it's palpable. When you sit in a room and you have that conversion that's what you want to see. And I have to keep emphasizing that it's not just about patients looking like one another, but it's about the physicians that see them or the health care workers that see that having a cultural competency around understanding what their circumstances and making sure we meet them there. So I think the trust is important, but I also think we have to be very, very intentional about building that trust. We can't show up when there's a pandemic. Right? We developed that trust in the community in DC over time. And then when it was time for us to go back to those folks and say, "Do that." And so the last thing I'll say about that trust, when I first moved back to DC to practice surgical oncology, although I had gone to school there, et cetera, there were parts of DC I had never been to. And I remember coming to my office one day, and I told my team, "Every Sunday, I'm going to go to a church and talk about what we do at Howard and bring people into the neighborhood." And boy, what an education. But when people really did get in trouble and needed my care, they were like, "I saw you in church on Sunday." It's a very different conversation, right? trato showing up to see this guy who trained at MD Anderson, and you don't think he can speak your language. Not to mention, you know how pastors are. They tell you to show up at 12:00. You get there at 12:00, sermon just started, and they have to interrupt the sermon so you could speak. So people are like, "Yeah, this guy, he's willing to come into our neighborhood, spend time with us." And so I think it's very, very important that you're very intentional about it.

Uché Blackstock 35:05

Yeah. That meant a lot to them. Okay. Dr. Goldberg?

Allison Goldberg 35:07

Yes. So what I would add to that is that we also have that strong belief that durable systems can only be built if you invest in trust, you build trust, you invest in community-led solutions, and you build and invest in sustainability. And so, because you mentioned vaccinations, I think about this innovation that we catalyzed funding for in Indonesia. So an example of some of the catalytic funding that we provide is

through that program that I described earlier, where we’re investing in solutions that are identified by the community that can make a difference in closing gaps in care. And so we ended up supporting a partner in Indonesia that did something really interesting. They said, “We want to increase immunizations among children. We think the way to do that in informal school settings is to actually change our model of immunization and create change agents in the school system.” And so we said, “Okay. Go for it.” And within a year, they saw an 11 percent increase in immunization coverage in the school system. That soon cascaded to the potential for scale. And so what we’re really proud of is that it’s not just about where our funding starts with, right? It’s catalytic. But how does that get absorbed for the potential for scale and sustainability? So that program now has established partnerships at the district and national level. It’s also influenced Ministry of Health guidelines. So that’s the kind of thing that we want to see, and that couldn’t have been possible if trust wasn’t established, if we didn’t really lean on community-led solutions and support local sustainable decisions around where investments should go.

A.C. Locklear 36:56

I can't say "tribal self-governance" and "tribal-run health facilities and systems" enough. It goes back sort of to what Dr. Frederick said, but being able to no longer depend on Indian Health Service to provide your care, having your tribe and tribal government be that entity. It was not very long ago, within my parents' lifetime, when it was Indian Health Service policy to sterilize Native women. That's the reality. So when women, when people went to Indian Health Service, it was out of absolute necessity. It wasn't to go for their normal annual physical. It wasn't to go for their dental checkup. It was because they had no other option. And really changing that mentality in tribal communities — that you can go, and there's preventative care, and you can go and speak your language. You can go and see folks who look like you, who are represented. But the reality is, we don't have a tribal medical school, right? That's something that is now being talked about. We don't have tribal GMEs, Graduate Medical Education programs. We see things like the Dental Health Aide programs and how successful they are in bringing American Indian and Alaska Native people through the system and being able to see those people represented within health care. But that's something we talk to our partners a lot about when they come to us and ask, "How do we get and build trust in tribal communities?" Whether it's pharma, whether it's whomever, it's not just going and having a conversation and trying to ingratiate yourself within the community. You have to invest in the full cycle, everything from investing in Native researchers, right? If you have Native researchers who are doing this work, tribal members are going to have a lot more trust, and they're going to want to be involved, and they're going to want to see the benefits. When tribes were giving out the vaccines during COVID, it was a completely different distinction than in those communities where they weren't. There were lines out the parking lot. But in urban communities, urban settings, those rates were very low comparatively. So we see all the things that we've said, and we see those investments and those partnerships as being critical to really changing the way we think about the entire system and building that trust.

Uché Blackstock 39:16

Thank you.

Kent Thoelke 39:17

Yeah, I think the trust thing is one. We talk a lot about community and patients. On the other side of this are the caregivers, right, and the physicians. So we're an AI company. We go into rural and community

settings. We talk about using AI to streamline access, to read the medical records, to match patients, to enter data, and it's an amazing story to me. And so I walk into a community health care system — I had this conversation a couple of weeks ago — and I said, "So, we take scarcity and make abundance." So today, for a clinical trial, there has to be somebody there after the physician treats the patient to enter all the data for what happened to that patient into a system, to collect it, to understand how the drugs are working. And so I'm like, "This will be amazing. Now you won't have to do that. We can use AI to read the records. Nobody has to manually enter data." Sounds amazing to me. You know what those people heard? "You're going to take our jobs." And so the trust quotient is different depending on who you're talking to. And for people, when you talk about AI in this country, especially rural and community systems, AI is a threat to them. So then the dialogue has to change around education on how this will make your job better. In those conversations, for those communities, this is an opportunity to put more patients into clinical trials with the same people you have today, right? So it is how you have those conversations, because you can imagine the first thing — if you break that trust, then they're like, "Well, we don't want to do that," right? And then everybody loses. So the patients lose, for sure. And so we try to make sure that we're meeting the caregivers and the physicians and the research people where they are as well.

Uché Blackstock 40:49

Yeah. So it sounds like there are so many stakeholders that are involved, right? And that there are so many layers, and that the investment can't be successful if there isn't trust embedded in the execution. So I have a question—and the QR code is up on the screen if you would like to submit questions—but I have a question from the audience. What's the most compelling example you've seen of an investment in health equity that paid off both in outcomes—I'm assuming in patient outcomes—and in economic terms? And partly, I also wanted us to spend this last time talking about solutions. So if you can maybe share projects or programs, things you've seen that have really been successful, both in terms of patient outcomes and economic outcomes as well. I mean, so whoever wants to go first...

Kent Thoelke 41:40

I do think that we have a case study in both North Dakota and in rural Arkansas. And in both cases, we deployed the AI into the health care system to automate the ability to match patients into trials. In North Dakota, we increased, on a yearly basis, the number of patients going into trials from 10,000 to 20,000 patients. That doesn't sound like a big number, unless you live in Grand Forks, North Dakota. It's a very big number. And that's not just 10,000 patients. It's 10,000 patients who got access to oncology medications and oncology trials that absolutely changed their trajectory on whether they will live or die, or whether they will live an extra year or two, or whether they will live with a better quality of life. And so for that health care system, the outcomes for patients are better. Those health care systems also receive revenue from participating in clinical trials, so it feeds itself for that scale. Same thing in rural Arkansas, where there's a tremendous opportunity, but the socioeconomic impact for those patients is massive. They have almost no access because of where they sit relative to socioeconomic structure, and so they couldn't access trials if they wanted to. Because they couldn't access health care or access those meds, the trials give them that access. And that increase was about 145 percent in a year. So these are things that actually happen today, and the impact is real across the entire ecosystem.

Uché Blackstock 43:05

Anyone else?

Wayne A. I. Frederick 43:06

Yeah. You know, it's graduation week, so my mind is—this is my favorite week of the year. My wife said, "Graduation is Saturday". And the reason why it is, is because I see something every year that I think we all, as a nation of citizens, should really stop and pause and celebrate. Howard was founded on March 2, 1867, and the charter was signed by the 17th president of the United States, Andrew Johnson, the first president to be impeached. And our democracy, as messy as it is, and as much as we have so much strife in our system, the reality is that this federal government started a university that sent the first woman to the vice president's office. It has transformed what the, I would say, middle class looks like in terms of African American representation. And when you look at 105 historically Black colleges and universities in this country, this weekend will produce graduates that will absolutely disperse across this country in an incredible way, but still, to this day, account for almost 25 percent to 30 percent of all the African Americans who will receive bachelor's degrees in STEM disciplines. You look at Congress. It accounts for 30 percent to 40 percent of the Black congressmen and women. I could go on and on. And so I say, in terms of when we're talking about investment, that education pipeline is so critical to what I think happens. And obviously, that leads to where we are in medicine, et cetera, as I pointed out earlier. But the point is that it started, again, with our government doubling down and making the right kind of investment. And I think as much as we squabble over the reach of the government, and we could go back and forth about our politics, the reality is, on Saturday, I'll be celebrating the US's investment, I think, in our historically Black colleges and universities.

Uché Blackstock 45:10

Thank you.

Allison Goldberg 45:12

The example I'd be remiss not to mention is, I think, one of the most powerful examples in public-private partnership. And so nearly 40 years ago, Merck, in partnership with the US government at the time and the World Health Organization, made a commitment towards the Mectizan Donation Program, which was the focus of eliminating river blindness, and now it's lymphatic filariasis around the world. And so we made this commitment nearly 40 years ago. It was CEO-led. Ken Frazier, decades later, also became a major proponent of it. And it was an important symbol for a few things. One was that we can make a difference not only in making a global health impact, but that through consistent, lasting partnership, we could actually eliminate disease. So today, we've delivered more than five billion treatments around the world. On average, 300 million people benefit from this treatment, and it reaches 62 countries around the world. So it's an example of the impact of lasting partnership. It's the power of making a major impact on global health, but also the economic implications are critical. These are populations that were greatly impacted on quality of life, and because of this treatment, they have more opportunities.

Uché Blackstock 46:38

Thank you.

A.C. Locklear 46:39

Yeah, I think I mentioned a few examples — the Special Diabetes Program for Indians, all of the above. But I think the reality in Indian Country is Indian Health Service, which provides direct health care to many

tribal nations, is funded about $7 billion by the government. Its need is estimated at about $70 billion, $78 billion. And it's a federally run health system. And the only way for tribes to actually create a system, or to have health care in these rural areas on tribal reservations that actually meets the needs of their citizens, is to take those systems over themselves. They contract with the federal government, and they take it on and say, "Hey, we can do a better job." And it consistently shows that they can do better jobs. And now we see a lot more innovation across the board, where tribes who may not have the capacity because they are smaller to take those services on themselves are partnering with various health systems across the board. We see them partnering with Yale's health system up in Connecticut. We see them partnering with other health systems and not only just providing health care to their tribal members, but also to others in the community—whether they have folks who are working within the community, who are living around the community. And it's something that I personally hope to see more and more of, especially as rural health care is being challenged in a lot of ways, that tribal communities who are running their own health system can provide that health care to everyone around. And we see it really starting to take off, and the success is there.

Uché Blackstock 48:12

Okay. Thank you. So I want to be aware, we have about 12 and a half minutes left, but a few questions were submitted. Given the drawback of funding in so many areas, how do you believe the Rural Health Transformation program will advance health equity? And if I could just maybe have one or two people answer that, if you feel very strongly. Who feels strongly to answer that?

Kent Thoelke 48:33

I mean I do think that the Rural Health Care Transformation Fund and the way those dollars are being spent are challenging because it was state by state, right? But in systems where we interact with those health care systems, like the Dakotas with Sanford Health, it is absolutely impactful. And the fact that a massive health care system and employer like Sanford Health, working with the governor of South Dakota, can figure out how to deploy those funds in the models that we use — that is directly around health equity and health access for clinical trials. So that's probably our most impactful. But it's challenging because there are 50 states and 50 programs and 50 deployments. So…

Uché Blackstock 49:11

Anyone else? Okay. And then the follow-up is also for you, Kent. Your company seems to be well capitalized. Is that an indication that there is still appetite in the business and investor communities for continuing to focus on equity and access, despite the political environment?

Kent Thoelke 49:32

So, hang on. I remember, I think my grandmother said this at some point: "It's not always about the money, but it's always about the money," right? And so where there are aligned interests, I think that absolutely is true. The reality is, there is a massive amount of innovation and investment in biotechs and pharma in this country. And that, biotech and pharma companies win when clinical trials are well represented, and when the recruitment into clinical trials happens fast. The more we can compress the timeline to get answers, the more we can get more patients into trials, the faster we get drugs to market. The faster drugs get to market, the more revenue pharma makes. So it is this cycle that funds it. And so the investors that are in this space, there is a value to them to invest in this architecture and infrastructure because the end

product is aligned with what they're trying to do, which is to get more drugs to market. So in that case, yes, it makes sense. Is that true for everything? I don't think so. But in our case, it has worked very well, and we have a group of investors that are both aligned incentively, but also from a mission perspective, they believe in the mission. They believe in advancing health equity. And so, I was saying this earlier to somebody: for the first three years of the company, we didn't make any revenue. That takes a tremendous amount of courage and vision from a board and an investor group to say, "We're going to build the infrastructure so that it's there when we need to deploy.

Uché Blackstock 50:57

Thank you. So while we're on that, I really want to come up with some action items for the audience. What is one concrete action leaders in this room should take in the next 12 months if they're serious about advancing health equity?

Wayne A. I. Frederick 51:14

You know, I think one of the things that we should look at is our own environment, our companies. And Howard obviously is educating people, and so our mission is huge. But one of the things I looked at was who was really using our health care insurance and how they were using it. And so a few years back, I made a decision that certain employees who made less than a certain amount — that we would pay for all of their health insurance. Because as I looked at utilization, et cetera, I was seeing patterns that were concerning. And so now, when you make under a certain income threshold at Howard, we pay for your entire health insurance. And what we have seen is more people getting annual exams, et cetera. I think a lot of times, we think of the big problem, and we want to go out and kind of boil the ocean. And the reality is, in our own backyards, there are things that we could be doing with our employees and in our own local spheres of influence that could influence that. And so when I look at the number of catastrophic incidents that are taking place at Howard in terms of health care or health outcomes, it has certainly, I think, decreased because we have encouraged people and given them a path to be able to access the same care that we're more than willing to give to the community. We weren't supplying it to our own, but just by doing that, we've certainly created that opportunity.

Uché Blackstock 52:36

Okay.

Allison Goldberg 52:38

I would say there's no silver bullet, but maybe the closest thing to it is partnership. We've been at this conference for the past few days, and what we continue to hear is the opportunity for more effective collaboration. So I would say partnerships, thinking about a broader swath of stakeholders that you might work with, what that looks like, and making them fit for purposes for the challenges and opportunities ahead.

Uché Blackstock 53:07

Okay.

A.C. Locklear 53:07

Yeah, she stole mine.

Allison Goldberg 53:11

We didn't talk.

A.C. Locklear 53:11

Yeah, I can't say that enough. Partnerships, and I think reframing that a little bit more because there's so many mutual benefits to these partnerships and potential partnerships, but there's also so many innovations, and right now, there's so many areas and gaps that we need to fill, especially across Indian Country. So just really exploring where those partnerships can lie because there's so many areas that I think there are overlap in opportunities right now.

Kent Thoelke 53:40

I think, to Dr. Frederick's point earlier, the current environment is kind of messy, right? But at the core of it, I think conviction and staying true to the mission is important and to have that courage. So I think lots of people could have looked at the current environment and looked at Health and Human Services and CMS and the administration and the cuts and the funding and said, "That is not a space we want to be in. That seems too scary to me." But the reality is, I think all of the people in that system actually can agree that better health care for all Americans, everybody wins. And so we try to stay true to the conviction and the message and try to bring people around a common alignment to create action. And I think when you get to that commonality, it's easier to create action than it is to—if we start talking about health equity as a phrase, it puts people on their backs all of a sudden. And so it's how do you meet those people where they are to get to where we're going?

Uché Blackstock 54:39

I think—anyone else? Wayne? So I think that feels like the right place to land, because what I'm hearing is that health equity is not abstract. It actually lives in consistent, lasting partnerships, in representation, investing in your workforce, partnerships, and collaborations. So I think if we're serious about the economic case, it's not just about investing more, it's about investing differently, who gets to decide how we define impact, and also whether communities are truly part of the process. So I just want to thank our illustrious panel here for sharing their experiences and expertise. Would you help me give them a hand?

Panelists 55:21

Thank you.

Uché Blackstock 55:23

Thank you so much.

Panelists 55:25

Thank you.

Announcer 55:28

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